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CONTACT: MARILYN WILSON 615.507.6450 (OFFICE) 615.969.2619 (MOBILE)

NEW TENNCARE CONTRACT WITH FEDS APPROVED

LENGTHY NEGOTIATIONS LEAD TO FAIR COMPROMISE FOR TENNESSEE'S MEDICAID PROGRAM

Nashville – Governor Phil Bredesen announced today that TennCare has received the necessary federal approval to continue operating its managed care Medicaid program in its current form for three more years.

"I am extremely pleased we were able to successfully negotiate a resolution that will help us better serve the Tennesseans who rely on this program," Bredesen said. "I'm also grateful to Senator Alexander, Senator Corker and our entire congressional delegation for their unwavering bipartisan support and efforts to ensure Tennessee was treated fairly at the federal level."

TennCare's contract is an agreement between the state and the federal Centers for Medicare and Medicaid Services (CMS) that allows TennCare to 'waive' specific federal Medicaid rules in order to operate a managed care program. TennCare is the only Medicaid program in the country to enroll its entire population in managed care. The waiver also stipulates specific financial boundaries under which TennCare must operate, including how supplemental payments to hospitals are calculated and distributed to help offset some uncompensated care costs borne by hospitals.

"Although the process has taken much longer than anyone anticipated, the additional time for negotiation proved productive," said Dave Goetz, Department of Finance and Administration Commissioner. "We were able to secure an agreement that allows TennCare to pay \$115 million more to hospitals over the next three years to help offset uncompensated care than CMS' original proposal would have allowed."

In the past three years, TennCare has paid more than \$1.7 billion to hospitals to assist with uncompensated care costs through certified public expenditures, essential access payments, critical access payments, payments to Meharry Medical College and two additional one-time supplemental payments. These combined funding sources make up TennCare's uncompensated care pool of money designated to assist hospitals with charity care and Medicaid losses. The new waiver places a cap on these supplemental payments to hospitals.

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"The fact that the majority of the cap's impact occurs at the end of the three_year period does give the state time to incorporate this financing change into its budget," said Goetz. "However, it is now more crucial than ever that we protect TennCare's renewed financial and operational stability. There's no room for error over the next three years. The program will have to be managed with careful vigilance."

With a new waiver in place, TennCare has the needed authority to begin the process of opening the Standard Spend Down eligibly category designed for non-pregnant adults. Previous legal victories by the state paved the way for creation of this new eligibility category. Spend Down is an optional eligibility category designed to provide one year of TennCare coverage for certain people whose unpaid medical bills are so high that an individual is facing poverty. Currently, a similar eligibility category, medically needy spend down, is open to pregnant women and children.

"The new cap makes opening the TennCare rolls more difficult, but once we have more certainty about our financial position under the cap, our goal is to try and open the standard spend down eligibility category," Goetz said.

TennCare is Tennessee's expanded Medicaid program, providing health insurance coverage to 1.2 million Tennesseans, including 640,000 children. For more information about TennCare, visit www.tn.gov/tenncare.

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Additional Facts:

- The federal Centers for Medicare and Medicaid Services (CMS) must issue a new approval when the state's contract ends. TennCare's original agreement with CMS expired June 30, 2007, however, CMS granted six short-term extensions while financial negotiations were finalized.
- The initial annual cap proposal from CMS at nearly \$480 million would have meant a loss of more than \$385 million in forgone revenue over the three-year waiver period. The approved waiver places an annual \$540 million cap on supplemental payments to hospitals, including CPE, bringing the future revenue loss down to less than \$270 million over the next three years.
- CPE is calculated based, on part, by the growth in the number of uninsured patients receiving treatment in hospitals and the cost of providing care to the Medicaid population. A cap on CPE means forgone revenue that TennCare typically receives from the federal government.